Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02079-10

Combined Assessment Program Review of the Central Alabama Veterans Health Care System Montgomery, Alabama

November 25, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Central Alabama Veterans Health Care System
FY	fiscal year
ICU	intensive care unit
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 25, 2014.

Review Results: The review covered seven activities and one follow-up review area from the previous Combined Assessment Program review.

Recommendations: We made recommendations in all seven activities and in the follow-up review area:

Quality Management: Ensure that the Critical Care Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the code, and that code data is collected. Review the quality of entries in the electronic health record. Include in the quality control policy for scanning how a scanned image is annotated to identify that it has been scanned. Ensure the Blood Usage Review Committee representatives from Surgery and Anesthesia Services consistently attend meetings.

Environment of Care: Ensure that actions are implemented to address high-risk areas and that Infection Prevention Committee minutes document those actions, reflect follow-up on actions implemented to address identified problems, and consistently reflect analysis of surveillance activities.

Medication Management: Ensure fluoroquinolone dosages and/or medications ordered at discharge are consistent with the discharge instructions and the pharmacy updates provided to the patient/caregiver.

Coordination of Care: Provide discharge instructions to patients and/or caregivers, and document this in the electronic health records.

Acute Ischemic Stroke Care: Develop an acute ischemic stroke policy that addresses all required items, and fully implement the policy. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the intensive care unit and acute inpatient unit. Provide a stroke educational program for employees. Provide printed stroke education to patients upon discharge. Collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Community Living Center Resident Independence and Dignity: Update care plans when residents' restorative care needs change, and reassess all residents for restorative nursing needs at the intervals required by local policy. Document resident progress

towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications. Require the Minimum Data Set Coordinator to collaborate with the Restorative Nurse to communicate pertinent minimum data set and quality indicator data to restorative nursing program staff.

Magnetic Resonance Imaging Safety: Establish written procedures for handling emergencies in magnetic resonance imaging (MRI). Conduct contrast reaction drills in MRI. Conduct initial patient safety screenings. Scan secondary patient safety screening forms into patients' electronic health records. Ensure radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan. Require that all designated Level 1 ancillary staff receive annual level-specific MRI safety training.

Follow-Up on Colorectal Cancer Screening: Ensure patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–34, for the full test of the Directors' comments.) We consider recommendation 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety
- Follow-Up on Colorectal Cancer Screening

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013 and FY 2014 through August 28, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama,* Report No. 11-03663-111, March 14, 2012). We made a repeat recommendation in colorectal cancer screening.

During this review, we presented crime awareness briefings for 321 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 229 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Critical Care Committee minutes had not been documented since January 2013: • There was no evidence that the committee reviewed each episode. • There was no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code. • There was no evidence that data were collected.
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include how a scanned image is annotated to identify that it has been scanned.

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage Review Committee meeting minutes reviewed: • The Surgery Service clinical representative attended only 6 of 12 meetings, and the Anesthesia Service clinical representative attended only 2 of 12 meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that code data is collected.

2. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

3. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee representatives from Surgery and Anesthesia Services consistently attend meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

At the Montgomery campus, we inspected the emergency department, the ICU, medical/surgical unit M3A, the Green Primary Care Clinic, the surgical clinic, SDS, the PACU, and the eye clinic. At the Tuskegee campus, we inspected the CLC; the acute MH unit; and the primary care, sleep, and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 13 employee training records (6 SDS and 7 PACU). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection prevention risk assessment and 3 months of Infection Prevention Committee meeting minutes reviewed: • Minutes did not reflect that actions were implemented to address high-risk areas.
X	Infection Prevention Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Three months of Infection Prevention Committee meeting minutes reviewed: • Minutes did not reflect follow-up on actions that were implemented to address identified problems. • Minutes did not consistently reflect analysis of surveillance activities.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
NA	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
NA	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Prevention Committee minutes document those actions, reflect follow-up on actions implemented to address identified problems, and consistently reflect analysis of surveillance activities.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
X	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	• Five EHRs (14 percent) contained discrepancies between the dosages and/or medications listed in the discharge instructions and the pharmacy updates provided to the patient/caregiver.
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

6. We recommended that processes be strengthened to ensure that fluoroquinolone dosages and/or medications ordered at discharge are consistent with the discharge instructions and the pharmacy updates provided to the patient/caregiver and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 9 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Six EHRs did not contain evidence that patients and/or caregivers were provided with discharge instructions related to restricted/special diets, weight monitoring, and/or wound care/dressing changes.
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions to patients and/or caregivers and document this in the electronic health records and that compliance be monitored.

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents and the EHRs of 18 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the emergency department, the ICU, and medical/surgical unit M3A. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility did not have a policy that addressed the management of acute ischemic stroke.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the eight applicable EHRs contained documented evidence of completed stroke scales.
NA	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the ICU or medical/surgical unit M3A.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the five applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• The facility did not provide a stroke educational program for staff.
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

10. We recommended that stroke guidelines be posted on the intensive care unit and the acute medical/surgical unit and that the facility provide a stroke educational program for employees.

11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

12. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 18 EHRs of residents (10 residents receiving restorative nursing services and 8 residents not receiving restorative nursing services but candidates for services). We also observed 2 meal periods, reviewed 11 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 3 of the 10 applicable EHRs, the care plans had not been updated to reflect all restorative services being provided.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In 5 of the 10 applicable EHRs, facility staff did not document resident progress towards restorative nursing goals or modification of interventions to promote the residents' accomplishment of goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	

NM	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	Local policies on resident assessment instrument and restorative nursing program reviewed, which require reassessment at specified intervals and communication of quality indicator data: • Six of the eight EHRs of residents who were candidates for restorative nursing services but were not receiving services did not reflect that the residents had been reassessed for restorative care needs within the past 12 months. • The Minimum Data Set Coordinator did not communicate pertinent minimum data set and quality indicator data to restorative nursing program staff.
	Areas Reviewed for Assistive Eating Devices and Dining Service	
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that care plans are updated when community living center residents' restorative care needs change and that all residents are reassessed for restorative nursing needs at the intervals required by local policy.

14. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document those modifications and that compliance be monitored.

15. We recommended that the Minimum Data Set Coordinator collaborate with the Restorative Nurse to communicate pertinent minimum data set and quality indicator data to restorative nursing program staff.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 36 employees (28 randomly selected Level 1 ancillary staff and 8 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 23 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• The facility did not have a policy that addressed procedures for handling emergencies in MRI. • Contrast reaction drills were not conducted in the MRI area.
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• None of the EHRs contained initial patient safety screenings. • None of the 23 completed secondary patient safety screening forms were retained in the EHR.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• None of the 18 applicable EHRs contained documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Four Level 1 ancillary staff did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

16. We recommended that the facility establish written procedures for handling emergencies in magnetic resonance imaging and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that contrast reaction drills are conducted in magnetic resonance imaging and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are scanned into the patients' electronic health records and that compliance be monitored.

20. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

21. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Review Activity with Previous CAP Recommendations

Follow-Up on Colorectal Cancer Screening

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with colorectal cancer screening.[h]

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive colorectal cancer screening test results unless contraindicated. The facility reviewed the EHRs of 125 patients who had positive fecal occult blood test results from January through June 2014. The facility reported that 19 of 85 patients (22 percent) did not receive diagnostic testing at the facility within the required timeframe and that 36 of 40 patients (90 percent) did not receive diagnostic testing through Non-VA Care Coordination within the required timeframe.

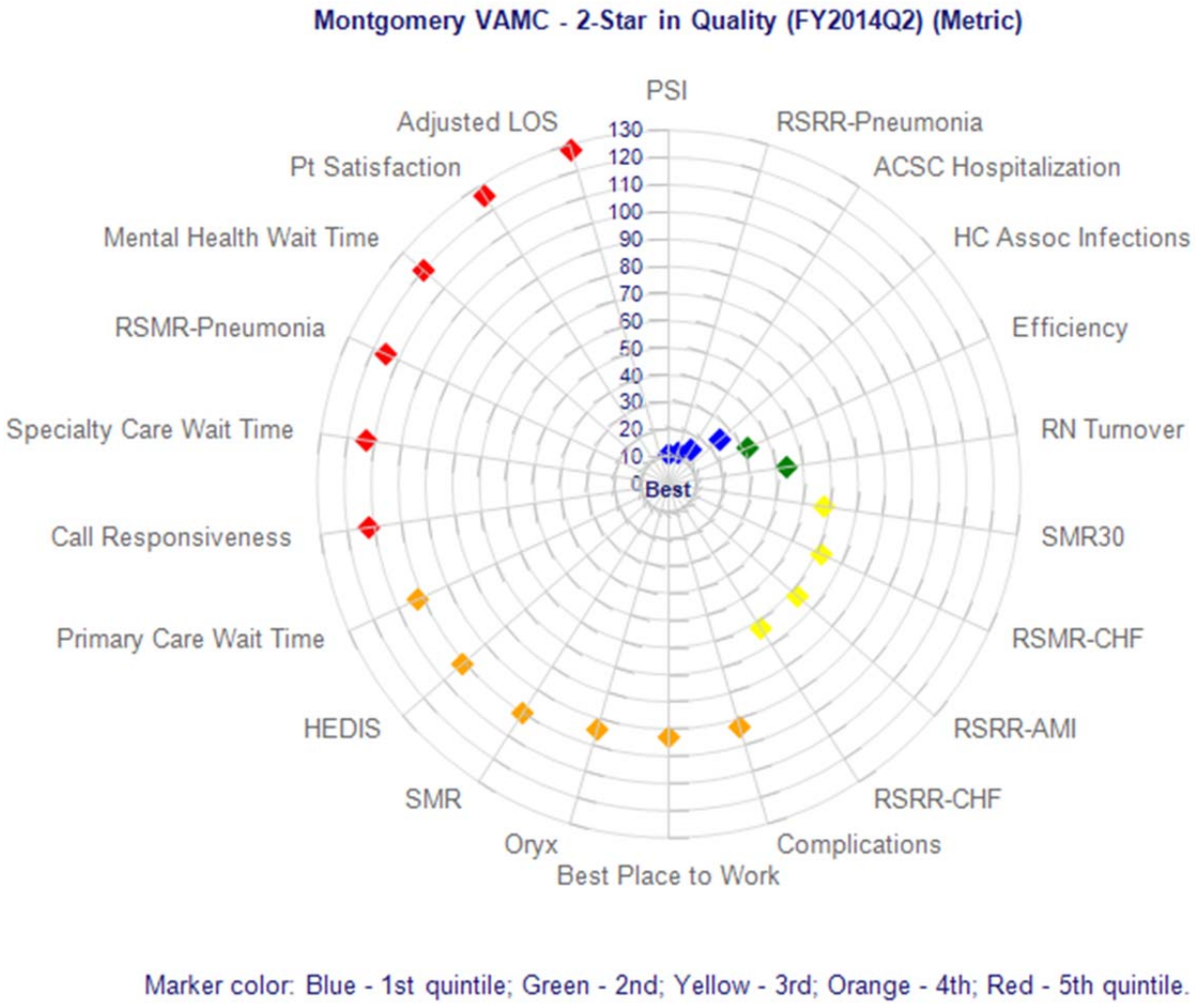
Recommendation

22. We recommended that processes be strengthened to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that compliance be monitored.

Facility Profile (Montgomery/619) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$232
Number of:	
• **Unique Patients**	43,772
• **Outpatient Visits**	362,676
• **Unique Employees**[2]	466
Type and Number of Operating Beds (as of July 2014):	
• **Hospital**	71
• **CLC**	160
• **MH**	73
Average Daily Census (as of July 2014):	
• **Hospital**	42
• **CLC**	83
• **MH**	70
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Columbus/619GA Dothan/619GB Wiregrass/619GD
VISN Number	7

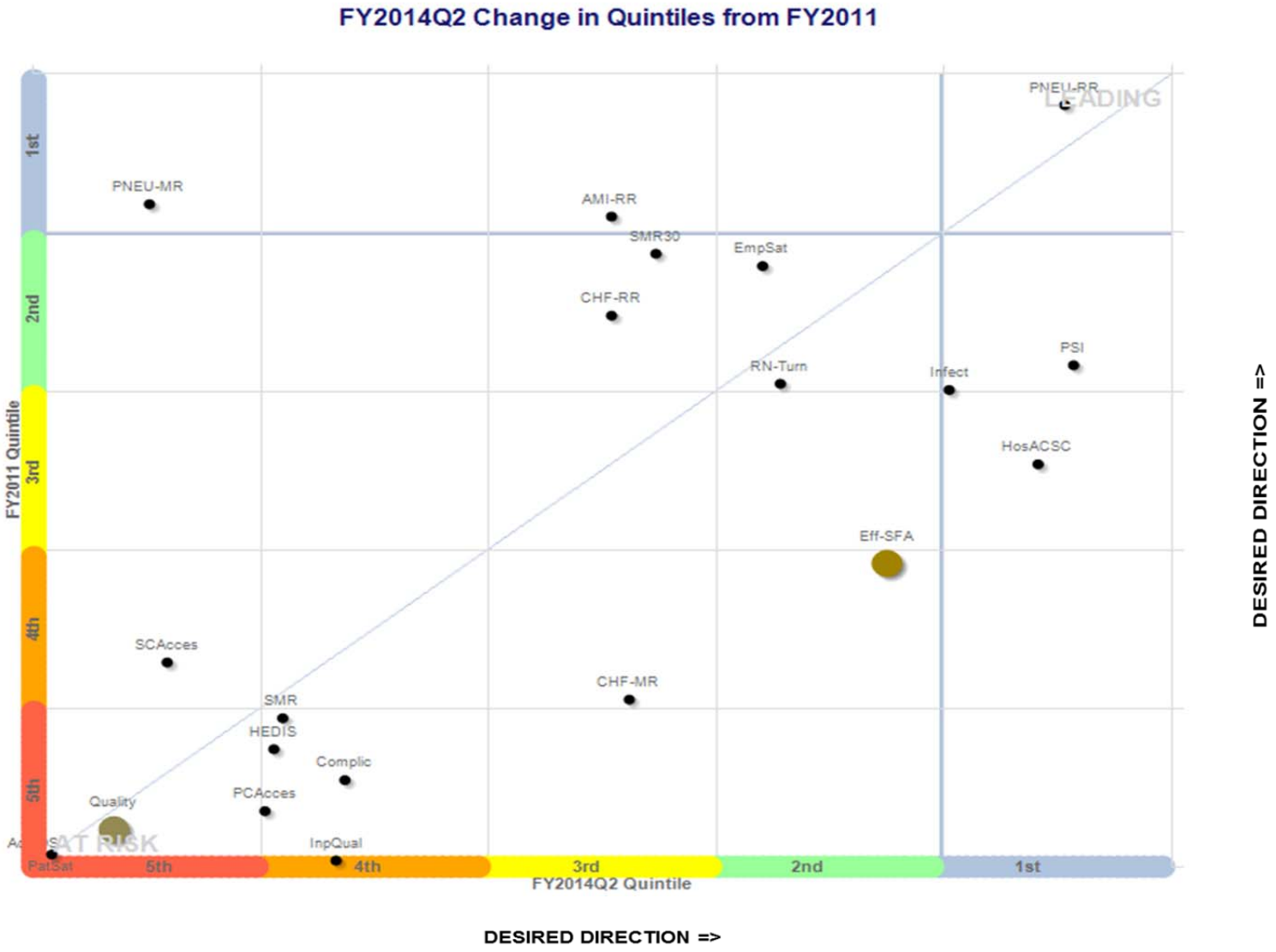
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 10, 2014

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Central Alabama Veterans Health Care System, Montgomery, AL**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed Central Alabama Health Care System OIG-Combined Assessment Program Review Report and concur with the report that indicated 22 findings. We appreciate the OIG's efforts to support CAVHCS's delivery of the highest quality of care to our Veterans.

2. CAVHCS has developed corrective action plans to address each of the recommendations timely with a projected completion date including appropriate monitoring of sustained compliance. The actions to improve care are attached.

3. If there are any questions, please contact Ms. Judy Finley, Acting VISN 7 Quality Management Officer, at (770)279-3419.

for Charles E. Sepich, FACHE

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 10, 2014

From: Acting Director, Central Alabama Veterans Health Care System (619/00)

Subject: **CAP Review of the Central Alabama Veterans Health Care System, Montgomery, AL**

To: Director, VA Southeast Network (10N7)

1. I have reviewed Central Alabama Health Care System OIG-Combined Assessment Program Review Report and concur with the report that indicated 22 findings. We appreciate the OIG's efforts to support CAVHCS' delivery of the highest quality of care to our Veterans.

2. CAVHCS has developed corrective action plans to address each of the recommendations timely with a projected completion date including appropriate monitoring of sustained compliance. The actions to improve care are attached.

3. If there are any questions, please contact Ms. Brenda Winston, Chief, Quality Management, at 334-272-4670, extension 6297.

Robin E. Jackson, PhD, MSW

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that code data is collected.

Concur

Target date for completion: 12/31/2014

Facility response:

The Critical Care Committee will

a. Add the review of resuscitation events and code data as a standing agenda item
b. Review all CPR/Rapid Response and Emergency Events.
c. Review all resuscitation episodes monthly. Deficiencies will be discussed and processes with appropriate actions will be taken. Items that require immediate attention or actions will be addressed promptly (out of committee)

The Critical Care Committee will also review each CPR/Rapid Response for the following

a. Errors or deficiencies in technique or procedures
b. Lack of availability or malfunction of equipment
c. Appropriateness of interventions performed against national standards of care
d. Clinical issues or patient care issues such as failure to rescue
e. Delays in initiating CPR/Rapid Response or Emergency Responses in-house and problems in obtaining the assistance of Emergency Medical Services or use of the 911-call system when the event occurs on campus
f. The debriefing sheet will be reviewed to ensure that screening for clinical issues prior to the code are identified

The debriefing sheet for all resuscitation events will be forwarded to the office of quality management within 24 hours of the resuscitation episode.

Quality Management will track and trend the data according to the components listed above. A report will be developed and reported to the critical care committee for follow-up as indicated.

Recommendation 2. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

Concur

Target date for completion: 12/31/2014

Facility response:

The Medical Record Committee approved the concurrent medical record review form to be used to report inconsistent documentation in the electronic health record. The form was forwarded to the Quality Leadership Board for final approval.

The Medical Record Committee agenda was revised in August 2014 to include a standing agenda item for service-level record review reports.

All service lines will be scheduled to submit and report Quarterly Reports based on monthly review rotation. Reports will be due the month in which the service is scheduled to report. The committee will review the report, make recommendations, and evaluate the effectiveness of action taken.

The process will be evaluated and monitored monthly and recorded in the Medical Record Committee meeting minutes and service line compliance/non-compliance will be reported to Quality Leadership Board for further action. By the end of first quarter Fiscal Year 2015, all services will have reported as least once.

Recommendation 3. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

Concur

Target date for completion: 10/03/2014

Facility response:

The current policy on scanning was revised during the time of the survey to note how a scanned image is to be annotated and how to identify that it had been scanned. This revision was approved on October 1, 2014 and posted in the policy file along with communication to the appropriate staff members.

Recommendation 4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee representatives from Surgery and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: 12/31/2014

Facility response:

In the September 17, 2014 Blood Usage Review Committee, the Acting Chair, and Quality Management representative reviewed the membership and responsibilities of each member. All members, including Surgical and Anesthesiology representatives were present. Additionally, appointment letters, signed by the Director were given to the Surgical and Anesthesiology representative, reiterating their appointments and required attendance to the committee meetings. The Chief of Staff and Quality Management will monitor attendance to ensure compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Prevention Committee minutes document those actions, reflect follow-up on actions implemented to address identified problems, and consistently reflect analysis of surveillance activities.

Concur

Target date for completion: 12/31/2014

Facility response:

Hand Hygiene practices were identified as a high-risk area. The Infection Prevention Committee will review and modified the processes to include enhanced surveillance.

An interdisciplinary team of observers has been identified to conduct random surveillance and report findings each month to the Infection Prevention Committee. The data will be gathered, tracked, and trended and the findings will be reported to the Infection Prevention Committee regularly.

Analysis of surveillance activity will be added as findings and observations in all Infection Prevention reports. A synopsis of any significant findings in surveillance monitoring will be discussed and annotated in committee minutes under the discussion section and monitored at the time the minutes are reviewed for signature/approval.

High-risk areas and associated follow-up actions will be added as meeting agenda items and reflected in committee minutes. Results of significant findings in surveillance monitoring data will be reported to the service area impacted for improvement strategies and reporting will be elevated to Clinical Leadership Board to ensure appropriate follow-up.

Quality Management will monitor these practices and provide oversight of reporting compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that fluoroquinolone dosages and/or medications ordered at discharge are consistent with the discharge instructions and the pharmacy updates provided to the patient/caregiver and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

The Pharmacists and the Ambulatory Care Providers discussed the best option to address compliance with medication dispensary and discharge instructions. The providers have been instructed to review all medication orders listed on the discharge summary to ensure consistency with medication dispensed from Pharmacy. If there is a difference in the medication list, the provider will add an addendum to the Medical Discharge Instructions for any changes made in prescribed medications. Instructions were discussed during the Service Line meeting of September 5, 2014.

For the next three months (through December 31, 2014) the Hospitalist will review all Medical Discharge Instructions for patients being discharged; and the medical record will be reviewed/monitored to ensure the documentation reflects that an addendum is entered to update the actual changes in antibiotics and other medications given to the patient. Findings will be reported to the Service Line Associate Chief of Staff and individual providers will be informed of their opportunities for improvement.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians provide discharge instructions to patients and/or caregivers and document this in the electronic health records and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

The Provider will provide discharge instructions to patients and/or caregivers, and document instructions provided in the electronic health record.

Nursing Service will monitor compliance by randomly selecting 10 percent of the monthly discharges and evaluate compliance.

Recommendation 8. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

The acute ischemic stroke policy has been developed according to the requirements in the associated VHA directive and is being routed for final approval and signatures. This is expected to be completed by 10/10/14. A primary stroke provider has been identified and a memorandum of understanding has been developed. The memorandum of understanding has been routed to senior leadership for signatures and compliance monitoring will be completed by Quality Management and reported to the Clinical Leadership Board for follow-up actions as necessary.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

The Associate Chief of Staff for Acute Care Services and designated Critical Care Committee members have instructed providers to use the standard National Institutes of Health stroke scale to identify and document patients with stroke. A paper form will be completed and scanned into the medical record until a template is developed to document in the electronic health record. By 10/15/2014, the Associate Chief of Staff of Acute Care Services, Acute Care Nursing staff, along with the Clinical Informatics staff will ensure development of the template for the electronic health record. Compliance monitoring will be completed by Quality Management and reported to the Clinical Leadership Board for follow-up actions as necessary.

Recommendation 10. We recommended that stroke guidelines be posted on the intensive care unit and the acute medical/surgical unit and that the facility provide a stroke educational program for employees.

Concur

Target date for completion: 9/30/2014

Facility response:

The National Institute of Health Stroke Guidelines have been posted in the Intensive Care Unit and the Acute Medical/Surgical Units by the nurse managers for each area. During quality rounds on 9/29/2014, all posters were visible and staff members were aware of the posting.

Ischemic Stroke Training has been added to the Talent Management System required training for all nurses and providers. All clinical staff and providers were assigned and all completed the training by the end of fiscal year 2014 (September 30, 2014 – 100 percent compliance with the training – with the exception of staff on extended military leave). The mandatory training will be added as annual training in Talent Management System and added to the orientation required training list for all new clinical employees and providers.

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

Beginning September 15, 2015, all patients discharged from the acute care setting will receive a stroke education brochure. The nursing staff will ensure the brochure is included in the discharge packet. Compliance will be monitored by Quality Management and reported to the Clinical Leadership Board for follow-up action as necessary.

Recommendation 12. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: 12/31/2014

Facility response:

Beginning October 1, 2014, Stroke data will be reported monthly to Quality Management from all inpatient units for the indicators listed. The data will be reported

to VHA national database and to the Critical Care Committee (for internal report monitoring, tracking, and trending). The stoke data will include the following indicators:

- The percent of eligible patients given tissue plasminogen activator
- The percent of patients with stroke symptoms who had the stroke scale completed
- The percent of patients screened for difficulty swallowing before oral intake

Recommendation 13. We recommended that processes be strengthened to ensure that care plans are updated when community living center residents' restorative care needs change and that all residents are reassessed for restorative nursing needs at the intervals required by local policy.

Concur

Target date for completion: 12/31/2014

Facility response:

a. All residents in the Community Living Center care plans have been reviewed and as of Sept 25, 2014, 100 percent of all residents have a current comprehensive care plan that includes individualized measurable goals and objectives for the restorative program. The Associate Chief Nurse and the Nurse Manager will review randomly selected medical records to ensure they are updated as needs change.
b. The care plan will be reviewed weekly for accuracy of assessment, problem identification, and interventions consistent with the restorative program.
c. The care plan monitoring tool will be completed weekly and reported to the Geriatric Chief Nurse to evaluate compliance and monthly reports will be provided to the Geriatric Sub-council.

Recommendation 14. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document those modifications and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

Immediately after the survey visit date, the Community Living Center Restorative Nursing Staff developed a Standard of Practice for the Community Living Center Restorative Program. By September 25, 2014, the Geriatric Leadership approved and signed the Standard of Practice document.

The Community Living Center nursing staff have completed the following actions:

a. All nursing staff review the standard of practice and policy for restorative nursing
b. The Restorative nursing template was developed and implemented
c. The nursing staff began the weekly monitoring of the restorative program using the restorative nursing monitoring tool.

The results will be reported the Community Living Center nursing leadership. Corrective actions will be taken for any outliers. Reports of monitoring, tracking, and trending will be reported quarterly into the Geriatric Sub-council.

Recommendation 15. We recommended that the Minimum Data Set Coordinator collaborate with the Restorative Nurse to communicate pertinent minimum data set and quality indicator data to restorative nursing program staff.

Concur

Target date for completion: 12/31/2014

Facility response:

The Restorative Nurse is a member of the Interdisciplinary Team. The Minimum Data Set Coordinator meets with the Interdisciplinary Team on a weekly basis to discuss the Centers for Medicare and Medicaid Service report and Minimum Data Set data, which includes the quality indicators for the restorative nurse program. The Team has been re-educated on the details of the Centers for Medicare and Medicaid Service 802 report. Each Team member is required to sign the report at the completion of the discussion.

Recommendation 16. We recommended that the facility establish written procedures for handling emergencies in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 9/30/2014

Facility response:

A magnetic resonance imaging policy was developed according to national guidelines; the policy was approved and signed on 9/2/2014 and has been communicated to all appropriate employees. It is now fully implemented. Compliance with the policy is being monitored by Quality Management and reported to the Clinical Leadership Board for follow-up actions as necessary.

Recommendation 17. We recommended that processes be strengthened to ensure that contrast reaction drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 9/30/2014

Facility response:

A contrast reaction drill was conducted on 9/3/2014, which included the magnetic resonance imaging lead technician and imaging staff. The Code Team Leadership, Acting Chief of Radiology, and Quality Management staff observed and evaluated the contrast drill. The response to the contrast reactions was appropriate and all conditions were fully met. The Code Review Team gave an outstanding rating for the code. The contrast codes are scheduled to be conducted annually and compliance will be monitored by Quality Management and reported to the Clinical Leadership Board for follow-up actions as necessary.

Recommendation 18. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: 12/30/2014

Facility response:

Providers were sent a list of patients who had a magnetic resonance imaging previously ordered but had not completed Level 1 screening. For these patients, the Level 1 screening was completed by the ordering provider or the Acting Chief of Radiology prior to the scan being done. Prior to any magnetic resonance imaging appointment, the Lead Technologist checks the magnetic resonance imaging order for the required screening form.

- As of September 1, 2014, the magnetic resonance imaging scheduler no longer schedules patients who do not have the Level 1 screening form completed.
- Providers received written notification of the necessity to complete the Level 1 screening form prior to ordering the magnetic resonance imaging.
- The magnetic resonance imaging ordering template has been revised; the provider must complete the screening form before the magnetic resonance imaging is ordered and scheduled.
- If a patient who was previously scheduled for a magnetic resonance imaging before September 1, 2014, arrives for an appointment and the screening form is not completed, the Acting Imaging Chief will interview the patient and complete the Level I screening form before the magnetic resonance imaging is done.
- September 8, 2014 a monitoring log was developed, implemented and is being completed daily by the magnetic resonance imaging scheduler. The log tracks the scheduling activity to evaluate compliance with the scheduling procedure. The Supervisor of imaging and Quality Management will monitor the progress and compliance of scheduling and completion of the Level 1 screening.

Beginning September 26, 2014 and ongoing, the Acting Imaging Chief is actively updating the magnetic resonance imaging ordering menu. The Acting Chief is also working with informatics to attach the questionnaire, making it mandatory to complete the screening.

Recommendation 19. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are scanned into the patients' electronic health records and that compliance be monitored.

Concur

Target date for completion: 10/30/2014

Facility response:

On September 3, 2014, a scanner was installed in the magnetic resonance imaging suite to scan-in the secondary patient safety screening forms. The magnetic resonance imaging technician scanned the level II form into the electronic health record immediately after the magnetic resonance imaging is completed. The Imaging Supervisor will evaluate compliance by conducting monthly random sampling of 20% of electronic health record of patients' records who had a magnetic resonance imaging. As of September, all level II screening forms were scanned into the electronic health record meeting the goal of 100 percent compliance.

On September 26, 2014, a second scanner was installed in imaging. Subsequently by October 7, 2014, five scanners were operational in imaging to scan older (stored) secondary screening forms. Scanning of these documents was started immediately. Additionally, all radiology staff members were trained and given access to scan in the documents.

All secondary screening forms (backlog) are expected to be completed by October 15, 2014.

Recommendation 20. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

The magnetic resonance imaging technician assesses, discusses with the patient, and documents any contraindications on the secondary patient safety screening forms in the electronic health record. If a contraindication is identified and the procedure can be done, a radiologist is notified and the procedure is done and an alert is sent to the provider.

The Imaging Supervisor will complete/coordinate compliance by conducting monthly random sampling of 20 percent of patients' records who had a magnetic resonance imaging to determine if contraindications were addressed, documented, and appropriate

actions were taken. This will be reported to the Clinical Leadership Board for follow-up actions as necessary.

Recommendation 21. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: 8/31/2014

Facility response:

The Level 1 magnetic resonance imaging Safety training is set up in Talent Management System as a mandatory requirement for designated Level 1 ancillary staff members. All designated staff members received the training by 8/31/2014 (with the exception of one staff member that is on extended leave). The training is offered as an annually required training and will be assigned to all designated staff training courses. Service Chiefs are electronically notified of any delinquent staff that has not completed training. The training will be included on the orientation required training list for all new designated staff.

Recommendation 22. We recommended that processes be strengthened to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that compliance be monitored.

Concur

Target date for completion: 12/31/2014

Facility response:

There is currently a process in place to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe.

Positive fecal occult blood test results will be checked daily and consults will be entered for each positive result.

The fecal occult blood test coordinator will monitor all fecal occult blood test consults weekly to ensure appointments are scheduled in a timely manner and missed appointments are rescheduled as appropriate.

Certified letters will be mailed to patients who no-show or cancel scheduled appointments on two different occasions.

The fecal occult blood test coordinator will submit a spreadsheet to Quality Management on a monthly basis to show tracking and monitoring of this process to account for all patients screened and their status.

Time sensitive monitoring will be included based on the policy.

The fecal occult blood test coordinator will present the findings of screening and compliance to the Quality Executive Board on a regular basis for appropriate follow-up actions.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Toni Woodard, BS, Team Leader Victoria Coates, LICSW, MBA Sheyla Desir, RN, MSN Joanne Wasko, LCSW Gilbert Humes, Special Agent in Charge, Office of Investigations Kendrick Stoudmire, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Jeff Joppie, BS Nathan McClafferty, MS Anita Pendleton, AAS Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Acting Director, Central Alabama Veterans Health Care System (619/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Sessions, Richard C. Shelby
U.S. House of Representatives: Robert Aderholt, Spencer Bachus, Mo Brooks, Bradly Byrne, Martha Roby, Mike Rogers, Terri A. Sewell

This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[h] The references used for this topic were:
- VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.